

Facility Name & ID Number Montebello Healthcare Center

0047340 Report Period Beginning: 01/01/2008 Ending: 12/31/2008

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds 139

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>139</u>	Skilled (SNF)	<u>139</u>	<u>50,874</u>	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>139</u>	TOTALS	<u>139</u>	<u>50,874</u>	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	<u>13,429</u>	<u>2,183</u>	<u>2,475</u>	<u>18,087</u>	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>13,429</u>	<u>2,183</u>	<u>2,475</u>	<u>18,087</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 35.55%

D. How many bed-hold days during this year were paid by the Department? 0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)
N/A

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES NO

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES NO

I. On what date did you start providing long term care at this location?
Date started 01/01/2005

J. Was the facility purchased or leased after January 1, 1978?
YES Date 01/01/2005 NO

K. Was the facility certified for Medicare during the reporting year?
YES NO If YES, enter number of beds certified 139 and days of care provided 1,979

Medicare Intermediary WPS

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

Is your fiscal year identical to your tax year? YES NO

Tax Year: 12/31/2008 Fiscal Year: 12/31/2008

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number Montebello Healthcare Center # 0047340 Report Period Beginning: 01/01/2008 Ending: 12/31/2008

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	93,917	10,310	6,933	111,160		111,160		111,160		1
2	Food Purchase		80,266		80,266		80,266	(24)	80,242		2
3	Housekeeping	55,196	11,463	29	66,688		66,688		66,688		3
4	Laundry	24,464	8,454		32,918		32,918		32,918		4
5	Heat and Other Utilities			109,551	109,551		109,551	(4,901)	104,650		5
6	Maintenance	17,398	40,696	7,947	66,041	(1,932)	64,109	5,431	69,540		6
7	Other (specify):*			12,273	12,273		12,273		12,273		7
8	TOTAL General Services	190,975	151,189	136,733	478,897	(1,932)	476,965	506	477,471		8
	B. Health Care and Programs										
9	Medical Director			7,200	7,200		7,200		7,200		9
10	Nursing and Medical Records	728,462	49,188	6,171	783,821		783,821		783,821		10
10a	Therapy		5,531	167,664	173,195		173,195		173,195		10a
11	Activities	29,102	1,941	3,968	35,011		35,011		35,011		11
12	Social Services	28,810		2,848	31,658		31,658		31,658		12
13	CNA Training										13
14	Program Transportation	23,260	3,013	25	26,298		26,298		26,298		14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	809,634	59,673	187,876	1,057,183		1,057,183		1,057,183		16
	C. General Administration										
17	Administrative	81,632			81,632		81,632		81,632		17
18	Directors Fees			500	500		500		500		18
19	Professional Services			1,267	1,267		1,267		1,267		19
20	Dues, Fees, Subscriptions & Promotions			20,529	20,529		20,529	(71)	20,458		20
21	Clerical & General Office Expenses	119,774	7,890	184,615	312,279		312,279	(81,523)	230,756		21
22	Employee Benefits & Payroll Taxes			179,155	179,155		179,155	6,137	185,292		22
23	Inservice Training & Education			2,120	2,120		2,120		2,120		23
24	Travel and Seminar			16,503	16,503		16,503	12,324	28,827		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			101,670	101,670		101,670	3,468	105,138		26
27	Other (specify):*										27
28	TOTAL General Administration	201,406	7,890	506,359	715,655		715,655	(59,665)	655,990		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,202,015	218,752	830,968	2,251,735	(1,932)	2,249,803	(59,159)	2,190,644		29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

STATE OF ILLINOIS

Report Peric Beginning: 1/1/2007
Ending: 12/31/2007

Facility Name & ID Number +Facility # 0039586

Meals - adjustment

18,087 Days (Total Patient days)
3 Mult (3 meals a day)
54,261 Sub total
0 meals to employess (reported by facility)
54,261 Add Sub
80,266 Divide -Pg 3, line 2, column 2
1.48 Cost per day

1.48 Cost per day

0 mult - meal to employees

- = adjust for pg 3, line 2, column 7

Personal Cable TV - in patient rooms

86004000004100 4,901

Sales Tax - adjustment

80,266 Total Food Cost (page 3,Line 2, col 2)
1.01 Div
0.01 Mult
794.71 Sub total
6.03% Mult (Pvt pay div by total census)/2
24 = adjust for nonallowable sale tax

Reclassification V

Page 3 Line 6 col 01

Repair & Maint <> Vehicles<>Default<>Prod<>Transp 830010000003850 (1,932) Reclass From
70% 2,761
Page 4 line 38 1,932 Reclass to

Page 3 Line 14 col 01

Salaries <> Regular<>Driver<>Transport Non<>Emergency 700000750403850 - Reclass From
Salaries Overtime/DbI Time<>Driver<>Transport Non<>Emergen 700500750403850 - Reclass From
Vacation Pay <> Earned Lve Acc.<>Default<>Prod<>Transport N 730012000003850 - Reclass From
(0 x 70% & 30%) 70% is Medical 30% is activities - total

Activities Page 3 line 11

Medical Page 4 line 38

- Reclass to

- Reclass to

-

Page 4 Line 35 Rent col 03

Lease Exp <> Vehicles<>Default<>Prod<>Transport Non<>Emer 841005000003850 - Reclass From
(0 x 70% = 0 lease for Medical)
Page 4 line 38 - Reclass to

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			30,506	30,506		30,506	(6,343)	24,163			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			(859)	(859)		(859)	13,707	12,848			32
33	Real Estate Taxes			51,392	51,392		51,392	293	51,685			33
34	Rent-Facility & Grounds			17,665	17,665		17,665		17,665			34
35	Rent-Equipment & Vehicles			5,407	5,407		5,407	5,958	11,365			35
36	Other (specify):*							12,070	12,070			36
37	TOTAL Ownership			104,111	104,111		104,111	25,685	129,796			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation					1,932	1,932		1,932			38
39	Ancillary Service Centers		34,996	9,984	44,980		44,980	17,396	62,376			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			76,311	76,311		76,311		76,311			42
43	Other (specify):*			250	250		250		250			43
44	TOTAL Special Cost Centers		34,996	86,545	121,541	1,932	123,473	17,396	140,869			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,202,015	253,748	1,021,624	2,477,387		2,477,387	(16,078)	2,461,309			45

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

Facility Name & ID Number Montebello Healthcare Center

0047340

Report Period Beginning:

01/01/2008

Ending:

12/31/2008

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.

In column 2 below, reference the line on which the particular cost was included. (See instructions.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms	(4,901)	5		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(24)	2		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(168)	21		18
19	Entertainment	(129)	24		19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(42,388)	21		24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(71)	20		28
29	Other-Attach Schedule				29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (47,681)		\$	30

BHF USE ONLY							
48		49		50		51	52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	174,984		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 174,984		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ 127,303		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1	2	3	4	
		Yes	No	Amount	Reference	
38	Medically Necessary Transport.			\$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

Montebello Healthcare Center

ID# 0047340

Report Period Beginning: 01/01/2008

Ending: 12/31/2008

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1	Marketing Wages (70%)	\$ (22,261)	21	1
2	Back Office Management Fees	(118,148)	21	2
3	Remove PY Adjustment for X-Ray Consultant	3,370	39	3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(137,039)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Montebello Healthcare Center

0047340

Report Period Beginning:

01/01/2008

Ending:

12/31/2008

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(24)	0	0	0	0	0	0	0	0	0	0	(24)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	(4,901)	0	0	0	0	0	0	0	0	0	0	(4,901)	5
6	Maintenance	0	5,431	0	0	0	0	0	0	0	0	0	5,431	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(4,925)	5,431	0	506	8								
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	(71)	0	0	0	0	0	0	0	0	0	0	(71)	20
21	Clerical & General Office Expenses	(182,965)	101,442	0	0	0	0	0	0	0	0	0	(81,523)	21
22	Employee Benefits & Payroll Taxes	0	6,137	0	0	0	0	0	0	0	0	0	6,137	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	(129)	12,453	0	0	0	0	0	0	0	0	0	12,324	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	3,468	0	0	0	0	0	0	0	0	0	3,468	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(183,165)	123,500	0	(59,665)	28								
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(188,090)	128,931	0	(59,159)	29								

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
SSC Equity Holdings, LLC	100	See Page 6.1				

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. YES NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization			
1	V	5	Utilities	SSC Equity Holdings, LLC	100.00%	\$	\$	0	1
2	V	6	Repair & Maintenance	SSC Equity Holdings, LLC	100.00%			5,431	2
3	V	39	Professional Services	SSC Equity Holdings, LLC	100.00%			14,026	3
4	V	20	Fees, Subscriptions & Promos	SSC Equity Holdings, LLC	100.00%			0	4
5	V	10	Nursing & Medical Records	SSC Equity Holdings, LLC	100.00%			0	5
6	V	21	Clerical & Gen Office Exp	SSC Equity Holdings, LLC	100.00%			101,442	6
7	V	24	Travel & Seminar	SSC Equity Holdings, LLC	100.00%			12,453	7
8	V	26	Insurance	SSC Equity Holdings, LLC	100.00%			3,468	8
9	V	36	Depreciation	SSC Equity Holdings, LLC	100.00%			12,070	9
10	V	33	Taxes - Property	SSC Equity Holdings, LLC	100.00%			293	10
11	V	35	Rental & Leasing	SSC Equity Holdings, LLC	100.00%			5,958	11
12	V	32	Interest Income/Expense	SSC Equity Holdings, LLC	100.00%			13,707	12
13	V	22	Payroll Taxes	SSC Equity Holdings, LLC	100.00%			6,137	13
14	Total		\$			\$	\$ *	174,985	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

**Related Illinois Nursing Homes
as of 12/31/2008**

Group Name	Related Illinois Nursing Homes	Illinois Facility Number
SSC Equity Holdings, LLC	Montebello Health Care Center	6006316
	Nature Trail Health Care Center	6006498
	Odin Health Care Center	6006878
	Westchester Health Care Center	6012173

Facility Name & ID Number Montebello Healthcare Center # 0047340 Report Period Beginning: 01/01/2008 Ending: 12/31/2008

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1									\$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Montebello Healthcare Center

0047340 Report Period Beginning: 01/01/2008 Ending: 2/31/2008

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES NO

Name of Related Organization SSC Equity Holdings, LLC
 Street Address 5300 West Sam Houston Pkw, Ste 100
 City / State / Zip Code Houston, TX 77041
 Phone Number (832) 467-6000
 Fax Number (832) 467-6114

B. Show the allocation of costs below. If necessary, please attach worksheets.

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	<u>5</u>	<u>Utilities</u>			\$	\$		\$ 0	1
2	<u>6</u>	<u>Repair & Maintenance</u>						5,431	2
3	<u>39</u>	<u>Professional Services</u>						14,026	3
4	<u>20</u>	<u>Fees, Subscriptions & Promos</u>						0	4
5	<u>10</u>	<u>Nursing & Medical Records</u>						0	5
6	<u>21</u>	<u>Clerical & Gen Office Exp</u>						101,442	6
7	<u>24</u>	<u>Travel & Seminar</u>						12,453	7
8	<u>26</u>	<u>Insurance</u>						3,468	8
9	<u>36</u>	<u>Depreciation</u>						12,070	9
10	<u>33</u>	<u>Taxes - Property</u>						293	10
11	<u>35</u>	<u>Rental & Leasing</u>						5,958	11
12	<u>32</u>	<u>Interest Income/Expense</u>						13,707	12
13	<u>22</u>	<u>Payroll Taxes</u>						6,137	13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$ 174,985	25

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1 Name of Lender	2 Related**		3 Purpose of Loan	4 Monthly Payment Required	5 Date of Note	6 Amount of Note		8 Maturity Date	9 Interest Rate (4 Digits)	10 Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related											
	Long-Term											
1							\$	\$			\$	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						\$	\$			\$	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						\$	\$			\$	14
15	TOTALS (line 9+line14)						\$	\$			\$	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ _____ Line # _____

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number Montebello Healthcare Center# 0047340 Report Period Beginning: 01/01/2008 Ending: 12/31/2008

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2007 report.		Important , please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	\$	59,431	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)			\$	55,825	2
3. Under or (over) accrual (line 2 minus line 1).			\$	(3,606)	3
4. Real Estate Tax accrual used for 2008 report. (Detail and explain your calculation of this accrual on the lines below.)			\$	54,998	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)			\$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)			\$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.			\$	51,392	7
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:					
2003	<u>53,913</u>	<u>8</u>			
2004	<u>54,772</u>	<u>9</u>			
2005	<u>57,210</u>	<u>10</u>			
2006	<u>60,259</u>	<u>11</u>			
2007	<u>55,825</u>	<u>12</u>			
			FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2007	\$			13
14	PLUS APPEAL COST FROM LINE 5	\$			14
15	LESS REFUND FROM LINE 6	\$			15
16	AMOUNT TO USE FOR RATE CALCULATION	\$			16

NOTES:

- Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.
- If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates RE: 2007 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2007 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2007.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2007 real estate tax bill to Healthcare and Family Services, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2008 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions,

2007 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Montebello Healthcare Center COUNTY Hancock

FACILITY IDPH LICENSE NUMBER 0047340

CONTACT PERSON REGARDING THIS REPORT Martha McDaniel

TELEPHONE 832 467 6317 FAX #: 832 467 6324

A. **Summary of Real Estate Tax Cos**

Enter the tax index number and real estate tax assessed for 2007 on the lines provided below. Enter only the portion of tl cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursir home property which is vacant, rented to other organizations, or used for purposes other than long term care must not l entered in Column D. Do not include cost for any period other than calendar year 2007.

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1. <u>11-29-999-119</u>	<u>Lot B Sub (Ex 2A SE Corner &</u>	<u>\$ 55,825.35</u>	<u>\$ 55,825.35</u>
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		<u>\$ 55,825.35</u>	<u>\$ 55,825.35</u>

B. **Real Estate Tax Cost Allocation:**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not direct used for nursing home services? YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing hom (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used

C. **Tax Bills**

Attach a copy of the original 2007 tax bills which were listed in Section A to this statement. Be sure to use the 20C tax bill which is normally paid during 2008

PLEASE NOTE: Payment information from the Internet or otherwise is not considered acceptable tax bill documentation. Facilities located in Cook County are required to provide copies of their original **second installment** tax bill.

Facility Name & ID Number Montebello Healthcare Center

0047340 Report Period Beginning:

01/01/2008 Ending:

12/31/2008

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 25,581 B. General Construction Type: Exterior Brick Frame Wood Number of Stories 1

C. Does the Operating Entity? (a) Own the Facility (b) Rent from a Related Organization. (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? (a) Own the Equipment (b) Rent equipment from a Related Organization. (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

N/A

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? YES NO
If so, please complete the following:

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____

3. Current Period Amortization: _____ 4. Dates Incurred: _____

Nature of Costs: _____
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1				\$	1
2					2
3	TOTALS			\$	3

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1	2	3	4	5	6	7	8	9	
	Bed* FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	139	2005	1974	\$	\$		\$	\$	\$	4
5										5
6										6
7										7
8										8
	Improvement Type**									
9	6 Ton 230V RTU		2005	27,558	2,756	10	2,756		9,187	9
10	Four Heat Run Duct System		2005	1,500	130	11.5	130		432	10
11	Repair Damaged Phone System		2005	1,576	158	10	158		525	11
12	Watermain Repair		2005	8,682	755	11.5	755		2,453	12
13	Retaining Wall - Partial Payment		2005	6,359	553	11.5	553		1,797	13
14	Fire Alarm Control Panel		2005	2,404	240	10	240		781	14
15	Construct Walkway Cover		2005	5,022	437	11.5	437		1,419	15
16	Leveled Ground around Stairway		2005	525	46	11.5	46		148	16
17	Fire Alarm System		2005	1,824	182	10	182		593	17
18	Install New Handrails		2005	415	36	11.5	36		117	18
19	Fire Alarm Control Panel		2005	872	87	10	87		283	19
20	Drywall Repairs - Water Break		2005	3,975	346	11.5	346		1,123	20
21	16: Toilet and Shower Floors		2005	10,166	897	11.3	897		2,766	21
22	Front Entry Concrete		2005	7,081	625	11.3	625		1,926	22
23	6: Smoke Detectors		2005	1,480	148	10	148		469	23
24	Relays for Emergency Lights		2005	2,776	245	11.3	245		755	24
25										25
26	119 Gallon Electric Water Heater		2006	4,362	436	10	436		1,272	26
27	Use Tax: Water Heater		2006	268	27	10	27		78	27
28	Install Water Heater		2006	659	66	10	66		192	28
29	Install Electrical Water Heater		2006	384	38	10	38		112	29
30	42' Sidewalk - Outside Patio		2006	1,820	179	10.175	179		418	30
31	Sprinkler		2006	2,296	226	10.175	226		527	31
32	Repair Sprinkler System		2006	6,893	689	10	689		1,493	32
33										33
34										34
35										35
36										36

*Total beds on this schedule must agree with page 2.

See Page 12A, Line 70 for total

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Montebello Healthcare Center

0047340

Report Period Beginning:

01/01/2008 Ending: 12/31/2008

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	Deposit - Vinyl Floor	2007	\$ 1,928	\$ 208	9.25	\$ 208	\$	\$ 295	37
38	Vinyl Flooring	2007	2,153	237	9.08	237		296	38
39	Replace AC Compressor - Laundry	2007	1,663	183	9.08	183		229	39
40	Sprinkler System Install	2007	1,744	190	9.16	190		254	40
41	Vinyl Flooring 2 Shower/Bathroom	2007	475	53	9	53		62	41
42									42
43									43
44	Backflow Devices - Sprinkler System	2008	21,646	2,630	9	2,630		2,630	44
45	Generator Water Pump	2008	4,412	386	8.58	386		386	45
46	Foundation Upgrade	2008	5,340	419	8.5	419		419	46
47	Sealed 3 Cracks Below Windows	2008	1,400	135	8.66	135		135	47
48	Water Abatement & Concrete Work	2008	2,670	185	8.41	185		185	48
49	Fire Alarm Maintenance	2008	3,191	161	8.25	161		161	49
50	Genset Wiring	2008	1,903	78	8.25	78		78	50
51	Generatro Remote Annunicator	2008	2,349	96	8.25	96		96	51
52	Dry System Accelerator	2008	8,020	405	8.25	405		405	52
53	Water Abatement & Concrete Work	2008	2,670	135	8.25	135		135	53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 160,459	\$ 14,801		\$ 14,801	\$	\$ 34,633	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Montebello Healthcare Center # 0047340 Report Period Beginning: 01/01/2008 Ending: 12/31/2008

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 51,432	\$ 5,595	\$ 5,595		5	\$ 11,329	71
72	Current Year Purchases	22,949	2,021	2,021		3	2,021	72
73	Fully Depreciated Assets	(8,404)	1,747	1,747		3	8,404	73
74								74
75	TOTALS	\$ 65,977	\$ 9,362	\$ 9,362			\$ 21,754	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				\$	\$	\$			\$	76
77										77
78										78
79										79
80	TOTALS			\$	\$	\$			\$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 226,436	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 24,163	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 24,163	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 56,387	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93			93
94			94
95		\$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: SMV Property Holdings, LLC

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?

If NO, see instructions. YES NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:	<u>1974</u>	<u>139</u>		\$ <u>17,665</u>	<u>12</u>		3
4	Additions							4
5								5
6								6
7	TOTAL		139		\$ 17,665			7

10. Effective dates of current rental agreement:

Beginning 01/01/2005
Ending 12/31/2016

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	<u>12/2009</u>	\$ <u>17,665</u>
13.	<u>12/2010</u>	\$ <u>17,665</u>
14.	<u>12/2011</u>	\$ <u>17,665</u>

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized by the length of the lease _____.

9. Option to Buy: YES NO Terms: _____ *

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental?

YES NO

16. Rental Amount for movable equipment: \$ _____ Description: _____
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$ _____	\$ _____	17
18					18
19					19
20					20
21	TOTAL		\$ _____	\$ _____	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number Montebello Healthcare Center # 0047340 Report Period Beginning: 01/01/2008 Ending: 12/31/2008

XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility.)

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. CLASSROOM PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>	<p>3. CLINICAL PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	-----------------------------------------------------------------------------------------------------------------------------------------------------------

B. EXPENSES

ALLOCATION OF COSTS (d)

		Facility		3	4
		1	2		
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training CNAs from other facilities.

\$

D. NUMBER OF CNAs TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
- (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
- (c) For in-house training programs only. Do not include fringe benefits.
- (d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

- (e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
- (f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	Service	1 Schedule V Line & Column Reference	2 Staff		4 Outside Practitioner (other than consultant)		6 Supplies (Actual or Allocated)	7 Total Units (Column 2 + 4)	8 Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	10 a-3	0 hrs	\$ 0						1
2	Licensed Speech and Language Development Therapist	10 a-3	0 hrs	0						2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10 a-3	0 hrs	0						4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescripts				34,996		34,996	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):									13
14	TOTAL			\$		\$	\$ 34,996		\$ 34,996	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number Montebello Healthcare Center# 0047340Report Period Beginning: 01/01/2008

Ending:

12/31/2008**XV. BALANCE SHEET - Unrestricted Operating Fund.**As of 12/31/2008 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 550	\$	1
2	Cash-Patient Deposits	(49,814)		2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	258,181		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	99,931		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 308,848	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	36,765		12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	160,459		15
16	Equipment, at Historical Cost	74,381		16
17	Accumulated Depreciation (book methods)	(56,386)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):	50,203		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 265,422	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 574,270	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 82,942	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	172,987		30
31	Accrued Taxes Payable (excluding real estate taxes)	13,670		31
32	Accrued Real Estate Taxes(Sch.IX-B)	55,825		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
36	Other Current Liabilities(specify):			
37		873		36
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 326,297	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
43	Other Long-Term Liabilities(specify):			
44	<u>Intercompany</u>	827,675		43
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 827,675	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,153,972	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ (579,703)	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 574,269	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (443,713)	1
2	Restatements (describe):	(22,099)	2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (465,812)	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	(113,891)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (113,891)	17
B. Transfers (Itemize):			
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ (579,703)	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Montebello Healthcare Center

0047340

Report Period Beginning: 01/01/2008

Ending: 12/31/2008

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required

classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

		1	
Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 3,071,294	1
2	Discounts and Allowances for all Levels	(1,054,148)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 2,017,146	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	282,827	6
7	Oxygen	5,115	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 287,942	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals	28	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	61,765	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	6,025	19
20	Radiology and X-Ray	563	20
21	Other Medical Services	(10,477)	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 57,904	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***		25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>Misc Receipts - Admin</u>	58	28
28a	<u>Misc Receipts - Vending</u>	446	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 504	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 2,363,496	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	478,897	31
32	Health Care	1,057,183	32
33	General Administration	715,655	33
B. Capital Expense			
34	Ownership	104,111	34
C. Ancillary Expense			
35	Special Cost Centers	44,980	35
36	Provider Participation Fee	76,311	36
D. Other Expenses (specify):			
37		250	37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 2,477,387	40
41	Income before Income Taxes (line 30 minus line 40)**	(113,891)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (113,891)	43

* This must agree with page 4, line 45, column 4.

** Does this agree with taxable income (loss) per Federal Income Tax Return? _____ If not, please attach a reconciliation.

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

**** Provide a detailed breakdown of "Other Revenue" on an attached sheet.

STATE OF ILLINOIS

Report Period: Beginning: 01/01/2008
Ending: 12/31/2008

Facility Name & ID Number Montebello Healthcare Center # 0047340

SUPPLEMENTAL SCHEDULE - OTHER INCOME

DESCRIPTION - Page 19, Line 28	Account Number	Amount
Miscellaneous ReceiptsDefault-ProdAdministrative	600057000008100	(58)
General Rental ReceiptsDefault-ProdAdministrative	600060000008100	0
Reconcile with Schedule XVII, Line 28		<input type="text" value="(58)"/>

DESCRIPTION - Page 19, Line 28a	Account Number	Amount
Miscellaneous ReceiptsDefault-ProdVending	600057000004102	(446)
Reconcile with Schedule XVII, Line 28a		<input type="text" value="(446)"/>

Facility Name & ID Number Montebello Healthcare Center

0047340

Report Period Beginning:

01/01/2008

Ending:

12/31/2008

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	1,476	1,752	\$ 43,961	\$ 25.09	1
2	Assistant Director of Nursing					2
3	Registered Nurses	4,886	5,421	132,593	24.46	3
4	Licensed Practical Nurses	11,284	12,431	203,383	16.36	4
5	CNAs & Orderlies	32,671	36,240	348,525	9.62	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,752	1,936	20,382	10.53	9
10	Activity Assistants	1,053	1,131	8,721	7.71	10
11	Social Service Workers	1,830	2,080	28,810	13.85	11
12	Dietician					12
13	Food Service Supervisor	1,980	2,116	21,838	10.32	13
14	Head Cook	3,303	3,500	27,612	7.89	14
15	Cook Helpers/Assistants	5,240	5,733	44,467	7.76	15
16	Dishwashers					16
17	Maintenance Workers	1,592	1,691	17,398	10.29	17
18	Housekeepers	5,598	6,201	55,196	8.90	18
19	Laundry	3,022	3,199	24,464	7.65	19
20	Administrator	1,840	2,104	83,018	39.46	20
21	Assistant Administrator					21
22	Other Administrative	3,852	4,268	97,826	22.92	22
23	Office Manager					23
24	Clerical	1,869	2,105	20,561	9.77	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)	1,577	1,775	23,260	13.10	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	84,825	93,683	\$ 1,202,015 *	\$ 12.83	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant		\$ 4,635	1-3	35
36	Medical Director		7,200	9-3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant		1,748	10-3	39
40	Physical Therapy Consultant		83,258	10a-3	40
41	Occupational Therapy Consultant		66,837	10a-3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant		17,569	10a-3	43
44	Activity Consultant		2,800	11-3	44
45	Social Service Consultant		2,848	12-3	45
46	Other(specify)				46
47	Xray Consultant		(1,025)	39-3	47
48					48
49	TOTAL (lines 35 - 48)		\$ 185,870		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses		\$		50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)		\$		53

Facility Name & ID Number Montebello Healthcare Center

0047340

Report Period Beginning: 01/01/2008

Ending: 12/31/2008

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions		
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount		
Rebecca Bliss	Administrator	0	\$ 81,632	Workers' Compensation Insurance	\$ 16,798	IDPH License Fee	\$		
				Unemployment Compensation Insurance	9,144	Advertising: Employee Recruitment	4,577		
				FICA Taxes	89,251	Health Care Worker Background Check	1,594		
				Employee Health Insurance	63,296	(Indicate # of checks performed)			
				Employee Meals		Patient Background Checks			
				Illinois Municipal Retirement Fund (IMRF)*		Non Allowable Advertising	4,298		
				Life Insurance	1,445	Dues	7,356		
				Other Benefits	5,358	Other Licenses	458		
						Subscriptions	2,176		
						Yellow Pages Advertising	71		
						Less: Public Relations Expense	()		
						Non-allowable advertising	()		
						Yellow page advertising	(71)		
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 81,632	TOTAL (agree to Schedule V, line 22, col.8)		TOTAL (agree to Sch. V, line 20, col. 8)		\$ 20,459	
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**		
Description			Amount	Description	Line #	Amount	Description	Amount	
			\$			\$	Out-of-State Travel	\$	
							In-State Travel	15,622	
							Meals	753	
							Entertainment	129	
							Seminar Expense		
							Home Office Allocation	12,453	
							Entertainment Expense	(129)	
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$	TOTAL		\$	TOTAL (agree to Sch. V, line 24, col. 8)		\$ 28,828
C. Professional Services									
Vendor/Payee	Type		Amount						
CT Corp			\$ 234						
My Innerview	Surveys, Resident, Family		195						
Press Ganey	Research		16						
Sec of State	Filing		250						
Taxc Corp	Unemployment Mgmt		555						
Viatch Publishing	TLC Program		18						
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 1,267						

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Montebello Healthcare Center

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? Yes
If YES, give association name and amount. Illinois Health Care Assn \$7,129
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? _____
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? _____
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 3
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 15,789 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. _____
- (9) Are you presently operating under a sublease agreement? _____ YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 76,311
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 0 Has any meal income been offset against related costs? _____ Indicate the amount. \$ _____
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ _____
c. What percent of all travel expense relates to transportation of nurses and patients? N/A
d. Have vehicle usage logs been maintained? Yes
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? Yes
Firm Name: BDO Seidman, LLC The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? No If no, please explain. Audit not completed yet
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$5,000, have legal invoices and a summary of services performed been attached to this cost report? N/A
Attach invoices and a summary of services for all architect and appraisal fees.

Item No.	Description	Quantity	Unit	Rate	Total
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